Oral hygiene care plan (including review of care plan)

Following the initial assessment, please complete the care plan below. After the review assessment, please complete a new care plan below. Please tick appropriate boxes. ☐

Initial assessment date: ____/_____/_____	Resident's mouth to be cleaned by resident/nurse/carer/relative (delete as appropriate) Resident needs prompting/reminding ☐ Resident needs supervision/checking of oral hygiene ☐	
Task	**Best time for cleaning**	**Products**
Teeth Brush teeth twice a day ☐		
Dentures Clean twice a day, rinse after meals, soak in water or recommended solution ☐		
Additional care/information e.g. management of dry mouth, lips, tongue and soft tissues, other problem associated with swallowing and nutrition, dexterity or cognitive function, referral to and advice from dentist.		
Signature		
Review assessment date: ____/_____/_____	Patient's mouth to be cleaned by patient/nurse/carer/relative (delete as appropriate) Resident needs prompting/reminding ☐ Resident needs supervision/checking of oral hygiene ☐	
Task	**Best time for cleaning**	**Products**
Teeth Brush teeth twice a day ☐		
Dentures Clean twice a day, rinse after meals, soak in water or recommended solution ☐		
Additional care/information e.g. changes in management of dry mouth, lips, tongue and soft tissues, other problem associated with swallowing and nutrition, dexterity or cognitive function, referral to and advice from dentist.		
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